COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 2, 2002

COMMONWEALTH OF VIRGINIA

At the relation of the CASE NO. INS-2002-00173

STATE CORPORATION COMMISSION

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing Minimum Standards for
Medicare Supplement Policies

ORDER TO TAKE NOTICE

Section 12.1-13 of the Code of Virginia provides that the Commission shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code of Virginia provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code of Virginia.

The rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code of Virginia are set forth in Title 14 of the Virginia Administrative Code.

The Bureau of Insurance has submitted to the Commission proposed revisions to Chapter 170 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Minimum Standards for Medicare Supplement Policies," which amend the rules at 14 VAC 5-170-20, 14 VAC 5-170-30, 14 VAC 5-170-60, 14 VAC 5-170-70,

14 VAC 5-170-105, 14 VAC 5-170-120, 14 VAC 5-170-130, 14 VAC 5-170-150, and 14 VAC 5-170-180

The proposed revisions incorporate changes required by federal law pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement Benefits Improvement and Protection Act of 2000, clarify loss ratio requirements in 14 VAC 5-170-120 and 14 VAC 5-170-130, and reflect the 2002 deductible and co-payment amounts under Medicare.

The Commission is of the opinion that the proposed revisions submitted by the Bureau of Insurance should be considered for adoption with an effective date of October 24, 2002.

ACCORDINGLY, IT IS ORDERED THAT:

(1) The proposed revisions to the "Rules Governing Minimum Standards for Medicare Supplement Policies," which amend the rules at at 14 VAC 5-170-20, 14 VAC 5-170-30, 14 VAC 5-170-60, 14 VAC 5-170-70, 14 VAC 5-170-105, 14 VAC 5-170-120, 14 VAC 5-170-130, 14 VAC 5-170-150, and 14 VAC 5-170-180, be attached hereto and made a part hereof.

(2) All interested persons who desire to comment in support of or in opposition to, or to request a hearing to oppose the adoption of, the proposed revisions shall file such comments or hearing request on or before September 10, 2002, in writing with the Clerk of the Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23218 and shall refer to Case No. INS-2002-00173.

(3) If no written request for a hearing on the proposed revisions is filed on or before September 10, 2002, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposed revisions, may adopt the revisions proposed by the Bureau of Insurance.

(4) AN ATTESTED COPY hereof, together with a copy of the proposed revisions, shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the proposed adoption of the revisions to the rules by mailing a copy of this Order, together with the proposed revisions, to all insurers, health services plans, and health maintenance organizations licensed by the Commission to write Medicare supplement insurance in the Commonwealth of Virginia.

(5) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the proposed revisions, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(6) On or before August 9, 2002, the Commission's Division of Information Resources shall make available this Order and the attached proposed revisions on the Commission's website, http://www.state.va.us/scc/caseinfo/orders.htm.

(7) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (4) above.

CHAPTER 170.
RULES GOVERNING MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES.

14 VAC 5-170-20. Applicability and scope.

A. Except as otherwise specifically provided in 14 VAC 5-170-60, 14 VAC 5-170-110, 14 VAC 5-170-120, 14 VAC 5-170-150 and 14 VAC 5-170-200, this chapter shall apply to:

1. All Medicare supplement policies delivered or issued for delivery in this Commonwealth on or after ~~September 1, 2001~~ October 24, 2002; and

2. All certificates issued under group Medicare supplement policies for which certificates have been delivered or issued for delivery in this Commonwealth.

B. This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

14 VAC 5-170-30. Definitions.

For purposes of this chapter (14 VAC 5-170~~-10 et seq.~~):

"Anticipated loss ratio" means the ratio of the present value of the future benefits to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide coverage.

"Applicant" means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy, the proposed certificateholder.

"Attained age rating" means a premium structure under which premiums are based on the covered individual's age at the time of application of the policy or certificate, and for which premiums increase based on the covered individual's increase in age during the life of the policy or certificate.

"Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this Commonwealth.

"Certificate" means any certificate delivered or issued for delivery in this Commonwealth under a group Medicare supplement policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Community rating" means a premium structure under which premium rates are the same for all covered individuals of all ages in a given area.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual did not have a break in coverage greater than 63 days.

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or Part B of Title XVIII of the Social Security Act of 1935 (Medicare) (42 USC § 1395 et seq.);

4. Title XIX of the Social Security Act of 1935 (Medicaid) (42 USC § 1396 et seq.), other than coverage consisting solely of benefits under § 1928;

5. Chapter 55 of Title 10 of the United States Code (CHAMPUS) (10 USC §§ 1071-1107);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under the Federal Employees Health Benefits Act of 1959 (5 USC §§ 8901-8914);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under § 5(e) of the Peace Corps Act of 1961 (22 USC § 2504(e)).

"Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical expense insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and

2. Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplement health insurance as defined under § 1882(g)(1) of the Social Security Act of 1935 (42 USC § 1395ss);

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code (10 USC §§ 1071- 1107); and

3. Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in the Employee Retirement Income Security Act of 1974 (29 USC § 1002).

"Insolvency" means when an issuer, duly licensed to transact an insurance business in this Commonwealth in accordance with the provisions of Chapter 10, 41, 42 or 43, respectively, of Title 38.2 of the Code of Virginia, is determined to be insolvent and placed under a final order of liquidation by a court of competent jurisdiction.

"Issue age rating" means a premium structure based upon the covered individual's age at the time of purchase of the policy or certificate. Under an issue age rating structure, premiums do not increase due to the covered individual's increase in age during the life of the policy or certificate.

"Issuer" includes insurance companies, fraternal benefit societies, corporations licensed pursuant to Chapter 42 of Title 38.2 of the Code of Virginia to offer health services plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this Commonwealth Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 (Public Law 89-97, 79 Stat. 286 (July 30, 1965)), as then constituted or later amended.

"Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in § 1859 (42 USC § 1395w-28(b)(1) of the Social Security Act, and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

3. Medicare+Choice private fee-for-service plans.

"Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of health service plans or health maintenance organizations, other than a policy issued pursuant to a contract under § 1876 of the federal Social Security Act of 1935 (42 USC § 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

14 VAC 5-170-60. Minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992.

A. No policy or certificate may be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

B. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

1. Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4. A “noncancellable,” “guaranteed renewable," or “noncancellable and guaranteed renewable” Medicare supplement policy shall not:

a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

b. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5. a. Except as authorized by the State Corporation Commission, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

b. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subdivision 5 d of this subsection, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(1) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(2) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection C of this section.

c. If membership in a group is terminated, the issuer shall:

(1) Offer the certificateholder the conversion opportunities described in subdivision 5 b of this subsection; or

(2) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

d. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of

termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

C. Minimum benefit standards.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

5. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible $100;

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

14 VAC 5-170-70. Benefit standards for policies or certificates issued or delivered on or after July 30, 1992.

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this Commonwealth on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

B. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more

restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes provided that loss ratios are being met.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

a. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

b. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subdivision 5 e of this subsection, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(1) Provides for continuation of the benefits contained in the group policy; or

(2) Provides for benefits that otherwise meet the requirements of this subsection.

d. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(1) Offer the certificateholder the conversion opportunity described in subdivision 5 c of this subsection; or

(2) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

e. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

7. a. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act of 1935 (42 USC § 1396 et seq.), but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

b. If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, the policy or certificate shall be automatically reinstituted (effective

as of the date of termination of such entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

c. Each Medicare supplement policy or certificate shall provide that benefits and premiums under the policy shall be suspended (for ~~the~~ any period that may be provided by federal regulation) at the request of the policyholder if the policyholder or certificateholder is entitled to benefits under § 226 (b) of the Social Security Act (42 USC § 426) and is covered under a group health plan (as defined in § 1862 (b) (1)(A)(v) of the Social Security Act (42 USC § 1395y)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of ~~such~~ the loss ~~and pays the premium attributable to the period, effective as of the date of termination of entitlement~~.

d. Reinstitution of ~~such~~ coverages as described in subdivisions 7 b and 7c of this subsection:

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(3) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

C. Standards for basic (core) benefits common to all benefit plans. Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each

prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount~~,~~ of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

D. Standards for additional benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by 14 VAC 5-170-80.

1. Medicare Part A deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled nursing facility care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty percent of the Medicare Part B excess charges. Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One hundred percent of the Medicare Part B excess charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic outpatient prescription drug benefit. Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

7. Extended outpatient prescription drug benefit. Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

8. Medically necessary emergency care in a foreign country. Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive medical care benefit. Coverage for the following preventive health services:

a. An annual clinical preventive medical history and physical examination that may include tests and services from subdivision 9 b of this subsection and patient education to address preventive health care measures.

b. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) Digital rectal examination;

(2) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(3) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(4) Serum cholesterol screening (every five years);

(5) Thyroid function test;

(6) Diabetes screening.

c. Tetanus and Diphtheria booster (every 10 years).

d. Any other tests or preventive measures determined appropriate by the attending physician. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-home recovery benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

a. For purposes of this benefit, the following definitions shall apply:

"Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

"Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

"Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

"At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

b. Coverage requirements and limitations:

(1) At-home recovery services provided must be primarily services which assist in activities of daily living.

(2) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare; and

(3) Coverage is limited to:

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(c) One thousand six hundred dollars per calendar year;

(d) Seven visits in any one week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

c. Coverage is excluded for:

(1) Home care visits paid for by Medicare or other government programs; and

(2) Care provided by family members, unpaid volunteers or providers who are not care providers.

11. New or innovative benefits. An issuer may, with the prior approval of the State Corporation Commission, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

14 VAC 5-170-105. Guaranteed issue for eligible persons.

A. Guaranteed issue provisions follow:

1. Eligible persons are those individuals described in subsection B of this section who, ~~subject to subdivision B2b of this section, apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in subsection B~~ seek to enroll under the policy during the period specified in subsection C of this section, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection ~~C~~ E of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B . An eligible person is an individual described in any of the following subdivisions:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide substantially all such supplemental health benefits to the individual~~.~~**;**

2.~~a~~. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under §1894 of the Social Security Act (42 USC § 1395eee), and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

~~(1)~~ a. The certification of the organization or plan has been terminated ~~or the organization or plan has notified the individual of an impending termination of such certification; or~~

~~(2)~~ b. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides~~, or has notified the individual of an impending termination or discontinuance of such plan or~~;

~~(3)~~ c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in § 1851 (g)(3)(B) of the federal Social Security Act (42 USC § 1395w-21) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under § 1856 of the Social Security Act (42 USC § 1395w-26)), or the plan is terminated for all individuals within a residence area; ~~or~~

~~(4)~~ d. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

~~a.~~(1.) The organization offering the plan substantially violated a material provision of the organization's contract under § 1859 of the Social Security Act (42 USC §§ 1395w-21 et seq.) in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

~~b.~~(2.) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

~~(5)~~ e. The individual meets such other exceptional conditions as the Secretary may provide.

~~b. (1) An individual described in subdivision 2a of this subsection may elect to apply subsection A of this section by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the~~

~~individual resides, but only if the individual disenrolls from the plan as a result of such notification.~~

~~(2) In the case of an individual making the election in subdivision 2b(1) of this subsection, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subsection A of this section shall only become effective upon termination of coverage under the Medicare+Choice plan involved.~~

3. a. The individual is enrolled with:

(1) An eligible organization under a contract under § 1876 of the Social Security Act (Medicare ~~risk or~~ cost);

(2) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(3) An organization under an agreement under § 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(4) An organization under a Medicare Select policy; and

b. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision B 2 of this section.

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a. (1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(2) Of other involuntary termination of coverage or enrollment under the policy;

b. The issuer of the policy substantially violated a material provision of the policy; or

c. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual 5.

a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization

under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under § 1876 of the Social Security Act (Medicare ~~risk or~~ cost), any similar organization operating under demonstration project authority, any PACE ~~program~~ provider under § 1894 of the Social Security Act (42 USC § 1395eee), ~~an organization under an agreement under § 1833(a)(1)(A)of the Social Security Act (42 USC § 1395) (health care prepayment plan)~~, or a Medicare Select policy; and

b. The subsequent enrollment under subdivision 5 a of this subsection is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under § 1851 (e) of the federal Social Security Act (42 USC § 1395w-21); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65 enrolls in a Medicare+Choice plan under Part C of Medicare, or with a PACE ~~program~~ provider under § 1894 of the Social Security Act (42 USC § 1395eee) and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

C. Guaranteed issue time periods.

1. In the case of an individual described in subdivision B 1 of this section, the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends 63 days after the date of the applicable notice.

2. In the case of an individual described in subdivisions B 2, B 3, B 5 or B 6 of this section whose enrollment is terminated involuntarily, the guaranteed issue periodbegins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

3. In the case of an individual described in subdivision B 4 a of this section, the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, or (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

4. In the case of an individual described in subdivisions B 2, B 4 b, B 4 c, B 5 or B 6 of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of disenrollment and ends on the date that is 63 days after the effective date of the disenrollment.

5. In the case of an individual described in subsection B of this section but not described in the subdivisions C1 through C4 of this subsection the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

D. Extended medigap access for interrupted trial periods.

1. In the case of an individual described in subdivision B 5 of this section (or deemed to be so described pursuant to this subdivision) whose enrollment with an organization or provider described in subdivision B 5 a of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision B 5 of this section.

2. In the case of an individual described in subdivision B 6 of this section (or deemed to be so described pursuant to this subdivision) whose enrollment with a plan or in a program described in subdivision B 6 of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls

in another plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision B 6 of this section.

3. For purposes of subdivisions B 5 and B 6 of this section, no enrollment of an individual with an organization or provider described in subdivision B 5 a of this section, or with a plan or in a program described in subdivision B 6 of this section, may be deemed to be an initial enrollment under this subdivision after the two-year period beginning on the date on which the individual first enrolled with such an organization provider, plan or program.

~~C~~ E. The Medicare supplement policy to which eligible persons are entitled under:

1. Subdivisions B 1, B 2, B 3, and B 4 of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F offered by any issuer.

2. Subdivision B 5 of this section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or~~,~~ if not so available, a policy described in subdivision 1 of this subsection.

3. Subdivision B 6 of this section shall include any Medicare supplement policy offered by any issuer.

~~D~~ F. Notification provisions are:

1. At the time of an event described in subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection A of this

section. Such notice shall be communicated in writing contemporaneously with the notification of termination.

2. At the time of an event described in subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection A of this section. Such notice shall be communicated in writing within 10 working days of the issuer receiving notification of disenrollment.

14 VAC 5-170-120. Loss ratio standards and refund or credit of premium; annual filing; public hearing.

A. 1. Loss ratio standards. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

a. At least 75% of the aggregate amount of premiums earned in the case of group policies; or

b. At least 65% of the aggregate amount of premiums earned in the case of individual policies,

calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section and meet the originally filed anticipated loss ratio when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the ~~appropriate~~ requirements of this section and the originally filed anticipated loss ratio ~~standards.~~

3. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet:

a. The originally filed anticipated loss ratio when combined with the actual experience since inception;

b. The greater of the originally filed anticipated loss ratio or the appropriate loss ratio requirement from subdivisions 1 a and 1 b of this subsection when combined with actual experience beginning with July 1, 1991, to date; and

c. The greater of the originally filed anticipated loss ratio or the appropriate loss ratio requirement from subdivisions 1 a and 1 b of this subsection over the entire future period for which the rates are computed to provide coverage.

B. 1. Refund or credit calculation. An issuer shall collect and file with the State Corporation Commission by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), ~~then~~ a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, for policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates. An issuer of Medicare supplement policies and certificates issued before or after July 30, 1992, in this Commonwealth shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the State Corporation Commission in accordance with the filing requirements and procedures prescribed by the State Corporation Commission. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the ~~appropriate~~ requirements of this section and the originally filed anticipated loss ratio ~~standards~~ can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

The supporting documentation shall also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the filing:

1. The assumptions present the actuary's best judgment as to the reasonable value for each assumption and are consistent with the issuer's business plan at the time of the filing;

2. The anticipated ~~lifetime~~ loss ratio, ~~future loss ratios,~~ and except for policies issued prior to July 30, 1992, the third-year loss ratios, ~~all~~ exceed the ~~applicable~~ requirements of this section and the originally filed anticipated loss ratio;

3. Except for policies issued prior to July 30, 1992, the filed rates maintain the proper relationship between policies which had different rating methodologies;

4. The filing was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board, including the data quality standard of practice, as described at www.actuary.org;

5. The filing is in compliance with the applicable laws and regulations in this Commonwealth; and

6. The premiums are reasonable in relation to the benefits provided.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement polices or certificates in this Commonwealth shall file with the State Corporation Commission, in accordance with the applicable filing procedures of this Commonwealth:

1. a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents, as necessary to justify the adjustment, shall accompany the filing.

b. An issuer shall make such premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

c. If an issuer fails to make premium adjustments acceptable to the State Corporation Commission, the State Corporation Commission may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public hearings. The State Corporation Commission may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 30, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the State Corporation Commission.

14 VAC 5-170-130. Filing and approval of policies and certificates and premium rates.

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this Commonwealth unless the policy form or certificate form has been filed with and approved by the State Corporation Commission in accordance with filing requirements and procedures prescribed by the State Corporation Commission.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the State Corporation Commission in accordance with the filing requirements and procedures prescribed by the State Corporation Commission.

The filing shall also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the filing:

1. The assumptions present the actuary's best judgment as to the reasonable value for each assumption and are consistent with the issuer's business plan at the time of the filing;

2. The anticipated ~~lifetime~~ loss ratio, ~~future loss ratios,~~ and except for policies issued prior to July 30, 1992, the third-year loss ratio ~~all~~ exceed the ~~applicable~~ appropriate loss ratio requirement from subdivisions 1a and 1b of subsection A of 14 VAC 5-170-120 and the originally filed anticipated loss ratio;

3. The filing was prepared based on the current standards or practices as promulgated by the Actuarial Standards Board including the data quality standard of practice as described at www.actuary.org;

4. The filing is in compliance with applicable laws and regulations in this Commonwealth; and

5. The premiums are reasonable in relation to the benefits provided.

C. 1. Except as provided in subdivision 2 of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the State Corporation Commission, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

a. The inclusion of new or innovative benefits;

b. The addition of either direct response or agent marketing methods;

c. The addition of either guaranteed issue or underwritten coverage;

d. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy or a group Medicare Select policy.

D. 1. Except as provided in subdivision 1 a of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after July 30, 1992, that has been

approved by the State Corporation Commission. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the State Corporation Commission in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate.

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to subdivision 1 a of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the State Corporation Commission of the discontinuance. The period of discontinuance may be reduced if the State Corporation Commission determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. A change in the rating structure or methodology shall be considered a discontinuance under subdivision 1 of this subsection unless the issuer complies with the following requirements:

a. The issuer provides an actuarial memorandum, in a form and manner prescribed by the State Corporation Commission, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

b. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The State Corporation Commission may approve a change to the differential which is in the public interest.

E. 1. Except as provided in subdivision 2 of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 14 VAC 5-170-120.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

14 VAC 5-170-150. Required disclosure provisions.

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age. Medicare supplement policies or certificates which are attained age rated shall include a clear and prominent statement, in at least 14 point type, disclosing that premiums will increase due to changes in age and the frequency under which such changes will occur.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is

required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have all premiums made for the policy refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person or persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

1. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the State Corporation Commission. The notice shall:

a. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

b. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. Such notices shall not contain or be accompanied by any solicitation.

C. Outline of coverage requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12 point type. All plans A--J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed in the following table.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s) _____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans.* This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

Basic Benefits: Included in all Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit		Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drug Benefit ($1,250 Limit)	Basic Drug Benefit ($1,250 Limit)	Extended Drug Benefit ($3,000 Limit)	

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year ~~$1580~~ $1620 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are~~$1580.~~ $1620 Out-of-pocket expenses for this deductible are expenses that woul ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

				Preventive Care					Preventive Care

PREMIUM INFORMATION

Boldface Type

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this Commonwealth. [If the premium is based on attained age of the insured, include the following information:

1. When premiums will change;

2. The current premium for all ages;

3. A statement that premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age; and

4. A statement that while the cost of this policy at the covered individual's present age may be lower than the cost of a Medicare supplement policy that is based on issue age or community rated, it is important to compare the potential cost of these policies over the life of the policy.]

DISCLOSURES

Boldface Type

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

Boldface Type

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

Boldface Type

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

Boldface Type

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

Boldface Type

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Boldface Type

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this

regulation. An issuer may use additional benefit plan designations on these charts pursuant to 14 VAC 5-170-80.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the State Corporation Commission.]

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PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	$0	~~$792~~ $812 (Part A Deductible)
61st thru 90th day	All but ~~$198~~ $203 a day	~~$198~~ $203 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day	~~$396~~ $101.50 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts		
First 20 days	All but ~~$99~~ $101.50 a day	$0	$0
21st thru 100th day	$0	$0	Up to ~~$99~~ $101.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

Rev. ~~9/01~~ 10/02

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		~~$792~~ $812 (Part A Deductible)	
First 60 days	All but ~~$792~~ $812		$0
61st thru 90th day	All but ~~$198~~ $203 a day	~~$198~~ $203 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day	~~$396~~ $406 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	$0	Up to ~~$99~~ $101.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

Rev ~~9/01~~ 10/02

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but $~~396~~ $406 a day	~~$396~~ $406 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0		$0
-Beyond the Additional 365 days	$0	100% of Medicare Eligible Expenses $0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts		
First 20 days	All but ~~$99~~ $101.50 a day	$0	$0
21st thru 100th day		Up to $~~99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN C (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $100 (Part B Deductible) 20%	$0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Rev. ~~9/01~~ 10/02

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days		~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$792~~ $812	Deductible)	$0
91st day and after:	All but ~~$198~~ $203 a day	~~$198~~ $203 a day	
- While using 60 lifetime reserve days			$0
- Once lifetime reserve days are used:	All but ~~$396~~ $406 a day	~~$396~~ $406 a day	
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	Up to ~~$99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	$0 $0 $0	Actual Charges to $40 a visit Up to the number of Medicare-approved visits not to exceed 7 each week $1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Rev. ~~9/01~~ 10/02

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day	~~$396~~ $406 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50	Up to ~~$99~~ $101.50 a day	$0
101st day and after	a day $0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

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PLAN E
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT * - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

*Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Rev. ~~9/01~~ 10/02

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year ~~[$1580]~~[1620]deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are ~~[$1580]~~ [1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day	~~$396~~ $406 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0		$0
-Beyond the Additional 365 days	$0	100% of Medicare Eligible Expenses $0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	Up to ~~$99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Rev. ~~9/01~~ 10/02

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year ~~[$1580]~~ [$1620] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are ~~[$1580]~~ [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $100 (Part B Deductible) 20%	$0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

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PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day	~~$396~~ $406 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	Up to ~~$99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $100 (Part B Deductible) $0
AT HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum	 $0 $0 $0	 Actual Charges to $40 a visit Up to the number of Medicare approved visits not to exceed 7 each week $1,600	 Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Rev. ~~9/01~~ 10/02

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day		$0
- Once lifetime reserve days are used:		~~$396~~ $406 a day	
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	Up to ~~$99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN H (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	 $0 $0 $0	 $0 50% - $1,250 calendar year maximum benefit $0	 $250 50% All Costs

Rev. ~~9/01~~ 10/02

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day		$0
- Once lifetime reserve days are used:		~~$396~~ $406 a day	
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	Up to ~~$99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

7/92

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN I (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $100 (Part B Deductible) $0
AT HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	 $0 $0 $0	 Actual Charges to $40 a visit Up to the number of Medicare Approved visits not to exceed 7 each week $1,600	 Balance

(continued)

PLAN I (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

Rev. ~~9/01~~10/02

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year ~~[$1580]~~ [$1620] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are ~~[$1580]~~ [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ $812	~~$792~~ $812 (Part A	$0
61st thru 90th day	All but ~~$198~~ $203 a day	Deductible)	$0
91st day and after:		~~$198~~ $203 a day	
- While using 60 lifetime reserve days	All but ~~$396~~ $406 a day	~~$396~~ $406 a day	$0
- Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$99~~ $101.50 a day	Up to ~~$99~~ $101.50 a day	$0
101st day and after	$0	$0	All Costs

PLAN J or HIGH DEDUCTIBLE PLAN J (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Rev. ~~9/01~~ 10/02

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year ~~[$1580]~~ [$1620] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are ~~[$1580]~~ [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	

PLAN J or HIGH DEDUCTIBLE PLAN J (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1580~~ $1620 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1580~~ $1620 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year			
Next $6,000 each calendar year	$0	$0	$250
	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT- NOT COVERED BY MEDICARE*** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

***Medicare benefits are subject to change. Please consult the latest *"Guide to Health Insurance for People with Medicare."*

D. Notice regarding policies or certificates which are not Medicare supplement policies.

1. Any accident and sickness insurance policy or certificate issued for delivery in this Commonwealth to persons eligible for Medicare, other than a Medicare supplement policy, a policy issued pursuant to a contract under § 1876 of the federal Social Security Act (42 USC § 1395 et seq.), a disability income policy, or other policy identified in 14 VAC 5-170-20 B, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision 1 of this subsection shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

E. Notice requirements for attained age rated medicare supplement policies or certificates.

Issuers of Medicare supplement policies or certificates which use attained age rating shall provide a notice to all prospective applicants at the time the application is presented and except for direct response policies or certificates, shall obtain an acknowledgement of receipt of the notice from the applicant. The notice shall be in no less than 12 point type and shall contain the information included in Appendix D. The notice shall be provided as part of, or together with, the application for the policy or certificate.

14 VAC 5-170-180. Standards for marketing.

A. An issuer, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

5. If the Medicare supplement policy or certificate uses attained age rating, all marketing materials or rate quotations other than the outline of coverage shall display prominently the following notice in close proximity to anywhere the insurer or agent displays a premium:

"Notice: This (policy's/certificate's) premium increases based on your attained age. Please read the *Notice For Attained Age Rated Medicare Supplement Policies carefully*." <u>It is available upon request or at the time the application is presented.</u>

6. Establish auditable procedures for verifying compliance with subsection A of this section.

B. In addition to the practices prohibited in Chapter 5 (§ 38.2-500 et seq.) of Title 38.2 of the Code of Virginia, the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert an insurance policy or to take out a policy of insurance with another insurer.

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms “Medicare supplement,” “Medigap,” “Medicare Wrap-Around,” and words of similar import shall not be used unless the policy is issued in compliance with this chapter.